

Medicaid Modernization Frequently Asked Questions



Medicaid Modernization: Iowa High Quality Health Initiative Responses to Stakeholder Questions

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This document is updated with the most recent information on a frequent basis. Please refer to the date in the footer of the document to confirm the most recently published version. New questions and sections with new questions are identified by blue, asterisk, bold, italic and underlined font: *NEW Question***

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The information provided in this document reflects the Medicaid Modernization as defined by the scope of work in the agency's request for Proposal (RFP), Iowa High Quality Healthcare Initiative, RFP# MED-16-009, issued February 16, 2015.

The Agency's written and oral responses to questions issued through this forum will not be considered part of the Iowa High Quality Healthcare Initiative RFP. If the Agency decides to change the RFP, the Agency will issue an amendment.

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General Questions

Section 1: What is Modernization?

Question: How does Medicaid Modernization affect the federal mandate that states have a close working relationship between Medicaid and Title V agencies?

Answer: Modernization does not affect that requirement.

Question: Given the complexity of the Money Follows the Person (MFP) program and requirements of the Centers for Medicare & Medicaid Services (CMS), can the MFP program be included in the excluded populations listed in 3.1.1.2?

Answer: The Long Term Care (LTC) services under MFP will be covered through Fee-for-Service (FFS) through the grant. Physical and behavioral health will be covered through the MCO, therefore the members cannot be excluded.

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Section 2: Covered Services

***NEW Question: When considering employment, it is very important to understand how SSA and Medicaid benefits will be impacted. Currently, benefits planning services are not specifically funded under Medicaid. Can MCOs be required or incentivized to provide this service?**

Answer: At this time, benefit planning is not funded under Medicaid and therefore it is not required. MCOs do have some flexibility in providing services outside of the Medicaid service package.

Question: What is planned for wraparound services such as transportation and interpretation currently provided by screening centers?

Answer: All services provided today will be available through the MCO. The MCOs will be responsible for care coordination of their members and establishing and maintaining the provider network to provide those services. After designated transition periods, it will be up to the MCOs to determine who they may choose to subcontract with and what providers are included in their network.

Question: Will case managers handle all cases or will they handle cases for a given population? Members can keep their case managers until June 30, 2016 – all case management set by MCO no later than December 31, 2016. Does this mean all or many of the present case managers will be out of business by the end of 2016?

Answer: Each MCO will determine how to manage case assignments for community based case management. The MCOs are responsible to provide the community-based case management and will determine if they will sub-contract with existing case

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management entities or provide the service directly. Section 2.9.7 Staff Training and Qualifications states that the Contractor (MCO) must ensure on an ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position and that staff training shall include population specific training relevant to the enrolled populations for all care managers.

Question: Social Security Laws related to managed care include exemptions as follows: “SEC. 1932 [42 U.S.C. 1396u-2], (a) STATE OPTION TO USE MANAGED CARE, (2) SPECIAL RULES. – (A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS—A state may not require under paragraph (1) USE OF MEDICAID MANAGED CARE ORGANIZATION AND PRIMARY CARE CASE MANAGERS) the enrollment in a managed care entity of an individual under 19 years of age who— (i) is eligible for supplemental security income under title XVI; is described in section 501(a)(1)(D), is described in section 1902(e)(3), is receiving foster care or adoption assistance under part E of title VI, or, is in foster care or otherwise in an out-of-home placement. Does Iowa plan to exempt these groups from participation in its Medicaid managed care program?

Answer: No, these groups will not be exempt. The Department will seek federal approval including these groups in the managed care program.

Question: I understand that assistive technology is not planned to be covered by MCOs. How will persons needing assistive technology receive those services under an MCO?

Answer: Services covered today will be covered tomorrow when medically necessary.

Question: Will an MCO cover HCBS home and vehicle modernization services? If so will they be required to provide current amounts covered by existing waivers?

Answer: Services covered today will continue to be covered tomorrow, when medically necessary.

Question: We have had many questions from families about individuals with Developmental Disabilities. Currently, they receive their targeted case management from Medicaid, but the services they receive are paid by regional, non-Medicaid dollars. Will these individuals be part of this transition?

Answer: Section 4.3(i) addresses who is eligible for Community-Based Case Management Requirements. It reads as follows: (i) targeted case management to members who are eighteen (18) years of age or over and have a primary diagnosis of mental retardation or who have a developmental disability as defined in Iowa Admin. Code 441 Chapter 90.1.

Question: Page 189 in the Home Health section doesn't appear to match the State Plan language for the Private Duty Nursing. Is there a typo that doesn't include shift nursing through EPSDT and lists only intermittent visits? How would the National Standards for Systems of Care for Children and Youth with special health care needs be implemented?

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Answer: This oversight was addressed in the second version of the RFP that was released on March 26, 2015.

Question: Do the current services under each of the HCBS waivers we know today remain as is under the Medicaid Modernization or should we expect there could be changes?

Answer: At this time the services under the HCBS waivers will remain the same. MCOs will be able to provide services that go beyond what is offered under the HCBS services. Any changes to the HCBS waivers will require public input, CMS approval and rule changes as they do today.

Question: What is the future of CDAC and CCO by persons who are currently served under HCBS waivers? There was much discussion about individuals being able to choose their providers within the selected network organized by the MCO, yet it is highly unlikely that approved individuals currently providing a service roll through CDAC or CCO will be selected as providers by any MCO as they are individuals, and not a large organization. Are there going to be some provisions allowed in the proposed changes, especially to allow for services for individuals who live in rural areas where provider options are already limited?

Answer: CDAC providers are currently part of the provider network within Medicaid. CCO providers are not considered within the Medicaid provider network but are contracted employees of the member. Both services are self-directed services. For HCBS waivers, the provider network will remain as is until December 31, 2017, which includes individual CDAC and CCO providers. Individuals providing personal attendant care are a cost effective way for services to be provided. Other states with managed care have individual providers through their self-directed services and Iowa will work with the successful MCO bidders to understand Iowa's current self-directed system. Self-direction is part of the array of service delivery options that the MCO is required to cover. Member choice is an essential component within the MCO provider network.

Question: The RFP does not specifically refer to requirements for children's mental health. This is not a question.

Answer: Children's Mental Health Services will continue to be covered as they are today.

Question: If I understood the comment correctly, the MCOs will contract with current Targeted Case Management (TCM) provider agencies to provide the community-based case management for Intellectual Disabilities (ID) and other waivers. It was further stated that the TCM providers are responsible for developing relationships with chosen MCO companies. Is this correct? When will the contracts for the MCOs be available? When will those contracts be due to the MCOs? Is it likely that the MCOs will contract with individual counties? Or would regional case management services be a likely contract instead of individual counties?

Answer: Current targeted case managers may continue to provide case management services until June 30, 2016. All case management services will be transitioned to the MCOs by December 31, 2016. The MCOs can choose to subcontract that work.

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Question: What is the plan for case management? Is the MCO going to contract with the counties? Many of these consumers do not have family members or parents to advocate for them therefore for many of them their case manager is their advocate. How can you take that away?

Answer: Current targeted case managers may continue to provide case management services until June 30, 2016. All case management services will be transitioned to the MCOs by December 31, 2016. The MCOs can choose to subcontract that work.

Question: Does Medicaid Modernization cover dental? How can dental care be received?

Answer: The dental services will be covered for Medicaid and *hawk-i* members as they are today. The dental services will not be part of the services provided by the MCO. Members of the Iowa Health and Wellness Plan will continue to use the Dental Wellness Plan for dental coverage. Children on *hawk-i* will continue to use the Iowa *hawk-i* dental plan. The rest of the Medicaid population will get dental coverage through Medicaid enrolled dental providers. In the future, the state plans to leverage the success of the Dental Wellness Plan for all populations.

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Section 3: Impact on Current Program

***NEW Question: Iowa has invested in provider and direct support staff training and certification over the past several years (College of Direct Supports, brain injury support worker training, and direct reimbursement for staff training within the waivers). Will this continue?**

Answer: The Department is continuing to provide the College of Direct Support and brain injury training tools for providers. Reimbursement of direct care staff training will be the MCOs.

***NEW Question: How does Medicaid Modernization impact the five-year implementation plan and timeline for the CMS Integrated Settings Rule? Will MCOs be responsible for the transition to the community settings with the providers in their network?**

Answer: MCOs shall be required to adhere to the Department's HCBS Settings Plan submitted to CMS. The Department will be working collaboratively and provide oversight of MCOs on implementation of these federal expectations.

***NEW Question: How does Medicaid Modernization impact the Balancing Incentives Program work and requirement for Single Point of Entry/No Wrong Door?**

Answer: MCOs shall be required to adhere to commitments made as part of the Balancing Incentives Program grant.

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***NEW Question: Section 1.2 of the RFP states that one of the goals of Medicaid Modernization is to “improve the quality of care and health outcomes for Medicaid and CHIP enrollees while leveraging the strength and success of current initiatives.” Much work has been done over the past few years on improving Medicaid employment services and supports and revamping rates to promote community-based services over more restrictive facility-based services. Is this work considered a current DHS initiative in the context of Section 1.2? If so, what is the state of the implementation of that work? If the employment work is NOT considered a current initiative, what will happen with that work as finalization of changes to Administrative Rules has yet to occur?**

Answer: The state will work with MCOs when finalization of this initiative occurs to ensure that employment for persons with disabilities continues to be an essential part of community living. There are specific outcome measures required in the RFP regarding an increase in employment for individuals.

***NEW Question: As a part of the employment services and supports work with Iowa Vocational Rehabilitation Services and their Employment First project, a Memorandum of Understanding exists between DHS and IVRS. Will MCOs be operating within the MOU?**

Answer: Yes, on behalf of DHS.

Question: Currently the Marketplace Choice Plan is available through Coventry on the Marketplace. These plans are currently paid at the commercial rate (Coventry's/Aetna's rate). Will this plan continue to be available on the Marketplace? Or will this move on January 1, 2016, to a Medicaid managed care plan?

Answer: Persons eligible for coverage in the Marketplace Choice Plan will receive services through a managed care organization beginning January 1, 2016. At that time, Medicaid will no longer purchase coverage through the qualified health plan (QHP) available on the Marketplace and that is currently provided by Coventry/Aetna.

Question: How will this affect the services through the Early Periodic Screenings, Diagnosis and Treatment (EPSDT) Cares for Kids Program (including the informing/rein forming process, transportation and care coordination services)? Will the MCOs take over this role and the care coordination, and develop their own transportation programs? How will these proposed changes affect the current positions/job responsibilities of current EPSDT staff members?

Answer: The MCOs will be responsible for care coordination of their members and establishing and maintaining the provider network to provide services. After designated transition periods, it will be up to the MCOs to determine who they may choose to subcontract with and what providers are included in their network. Medicaid fee-for-service will operate much like it does today. Beyond the requirements to contract with existing Medicaid providers for specified timeframes to allow for transition, the managed care organizations may contract with providers differently in the future.

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Question: Will providers be forced into an Accountable Care Organization?

Answer: Accountable Care Organization (ACO) contracting is not required by the RFP.

Question: Will these changes affect the current In Home Health Related Care program? If so, how?

Answer: In Home Health Related Care (IHHRC) is not a Medicaid program and therefore is outside of the purview of the RFP. However, coordination between Medicaid and IHHRC will continue to be essential to support the member in their home and to avoid duplication of services.

Question: Will the HCBS waivers be administered by the Department or the individual MCO?

Answer: The Department will retain the authority as the single state Medicaid agency to administer the seven HCBS waiver programs. The MCOs will be responsible for the day-to-day operations of the seven HCBS waiver programs.

Question: Does DHS still intend for the Transition Specialist to provide the community-based case management service for the 365 days after transition for the duration of the Money Follows the Person (MFP) grant?

Answer: Yes, it is expected that the Transition Specialist will provide the community-based case management services for the 365 days after transition for the duration of the MFP Grant.

Question: 4.3.10 Transition between facilities:

- Is the intent of this section to assure that the MCOs require community providers to strengthen discharge policies so that members are not discharged without alternative and appropriate services in place?
- Could there be penalties for the MCOs and/or the providers if involuntary discharges continue to happen?

Answer: Yes, this is the intent of the RFP. Currently there are no penalties attributed to the MCO for this specific reason but the MCO could attribute penalties to their provider network for inappropriate or excessive involuntary discharges.

Question: 4.3.12.1 Care Coordination Requirements: In the Money Follows the Person (MFP) program, the Transition Specialist performs this role. Does DHS intend that the Transition Specialist continue to provide outreach and advocacy to residents of facilities for the duration of the MFP grant and attend the residents' care planning meetings?

Answer: The MFP administrative vendor will be part of the planning process and the MFP transition specialist will focus on transition activities.

Question: 4.3.12.5 Community Transition Activities: In the Money Follows the Person (MFP) program, the Transition Specialist facilitates the development of the transition plan and

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assists the member with finding and arranging for community housing, supports and providers. Does DHS intend for the Transition Specialist to continue these activities for the duration the MFP grant?

Answer: The state's designee will continue to authorize services for the first 365 days. It is expected the Transition Specialist will continue these services for the duration of the MFP grant.

Question: 4.3.12.6 Post Transition Monitoring: The Money Follows the Person (MFP) Transition Specialist currently provides the post transition monitoring. Does DHS intend for the Transitions Specialist to continue this activity for the duration of the grant?

Answer: Yes, the Transition Specialist will continue this activity for the duration of the grant.

Question: Will there be the opportunity in the managed care program to expand the Money Follows the Person (MFP) program to the other waiver populations currently not served?

Answer: The MFP program is under the purview of DHS. DHS will continue to make decisions regarding the MFP program.

Question: Will it be the state or the MCO that will contract with the state's Money Follows the Person (MFP) designee to coordinate the MFP grant?

Answer: MFP will continue to be administered by DHS in partnership with an administrative vendor. The MCOs are required to coordinate with the MFP program.

Question: Have we looked into why we have so many new Medicaid recipients? What is the reason for the additional 21 percent growth over the next three years?

Answer: Most of the growth in both members and costs is due to the Iowa Health and Wellness Plan. The Iowa Health and Wellness Plan began in January 2014. This program is expected to add 150,000 new enrollees to the Medicaid program and nearly \$1 billion in new costs by State Fiscal Year 2017 (SFY17).

Question: In your presentation, the Iowa Medicaid Enterprise (IME) indicated the MCOs would authorize services based on "state policy and administrative rule". As part of this process, will state policies and administrative rules be reviewed and revised?

Answer: The MCOs will be required to follow the states policies and administrative rules about the authorization of services. The state will continue to review the service authorization policies and rules. Updates will be made as necessary, just as the state does today.

Question: How does this impact the Iowa Medicaid buy-in plan, which is Medicaid for Employed Persons with Disability (MEPD)?

Answer: The MEPD population will receive services through an MCO. MEPD members will still be expected to pay premiums. The premiums are a current program requirement. Eligibility for the MEPD program will not change.

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Section 4: Savings

Question: Can you provide additional information on how the state savings estimate of \$51.3 million was determined?

Answer: Various parties including vendors and other subject matter experts projected savings ranging from nominal (or little savings) to savings approaching 15 percent. Based on SFY2015 enacted appropriations along with the additional SFY2016 need, the Department's general fund budget request for the Medicaid program was \$1.36 billion for SFY2016. With projected savings at the midpoint of the range of estimates, we projected \$102.3 million in annual savings. Managed care will be implemented mid-way into SFY16, so the estimate for the final six months of the fiscal year is about \$51 million. This is the projected savings you see in the Governor's recommended budget and in information at the DHS website. Additional actuarial and internal reviews will allow us to further examine the estimated savings and make any necessary adjustments. The RFP is the beginning of this process, and contracts have not been awarded or negotiated, therefore there may be changes in certain projections as we conduct additional analysis.

Question: How will the state save \$51.3 million in the first six months? Will services be cut?

Answer: The MCO is responsible for the delivery of efficient, coordinated, high quality health care. The savings are based on improved management of the health care needs of the Medicaid members. That includes things like prevention of unnecessary hospitalizations, providing preventive care, and reducing duplication of services. The projected savings are not based on cutting services.

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Section 5: Federal Approval Process

Question: In the fact sheet, it states the Department is reviewing whether to seek a new 1115 waiver or amend. When will this determination be made?

Answer: DHS is working very closely with our federal partners at the Centers for Medicare & Medicaid Services (CMS) on the best route for approval as Iowa seeks to modernize the Medicaid program.

In order to secure federal approval for the Medicaid Modernization plan, Iowa will submit a concurrent 1915(b) and 1915(c) waiver authority. This means a new 1915(b) waiver application will be submitted to include physical health, behavioral health and long-term care services in the Medicaid managed care program. In addition, the

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Section 1115 Demonstration waivers (Iowa Wellness Plan and Family Planning) will be amended to transition service delivery to managed care organizations. The seven 1915(c) home and community based services waivers will also be amended to transition service delivery to managed care organizations. The Department anticipates posting the application and amendments for public comment by the end of June 2015. After reviewing the public's input, we anticipate formal submission of the waivers at the end of the summer.

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Section 6: Implementation Timelines

***NEW Question: What is the process going to be for communicating with providers on the transition to managed care by both DHS and the managed care organizations? What specific forms of media and outreach will be used?**

Answer: DHS and the MCOs will work with associations and network listings to collaborate transition activities. Specific forms of media and outreach are being developed and finalized through the Department's communication plan for this initiative.

Question: Moving all parts of health care coverage simultaneously in an ambitious time frame could jeopardize the stability of health care benefits and cause a financial/claims processing bottleneck. Would DHS consider additional phasing in of the implementation steps?

Answer: The Department will ensure that all MCOs are ready for operations prior to the January 1, 2016, implementation date. This includes ensuring that MCOs are capable of processing service authorizations and claims within the contractually required timeframes. The Department will work to ensure that continuity of care is achieved for all members as part of the existing timeline for implementation, and is committed to maintaining the existing timeline for implementation.

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Provider Questions

Section 7: Network and Rates

Question: The Affordable Care Act recognizes physicians, physician assistants (PAs) and nurse practitioners as primary care providers. Will Iowa be consistent with federal law in recognizing PAs as primary care providers by listing them separately as a provider in the directory of providers for Medicaid? If we are not listed by name, instead of under our supervising physician's name, this would decrease access and be confusing for our patients as they would think they could no longer see me as a patient.

Answer: All Medicaid services, including those operated under managed care, will be compliant with applicable federal laws. The RFP does not require a specific format for the searchable provider database but this suggestion will be taken into consideration during implementation.

Question: Can the contractor refuse to fund persons in a one or two star nursing facility?

Answer: In accordance with 6.2.2.1, the MCO is not permitted to execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid and/or CHIP programs, or who are otherwise not in good standing with the State's Medicaid program or Medicare program. Having a one or two star rating on Medicare's Nursing Home Compare website does not necessarily mean the facility has been excluded from participation in Medicare or Medicaid, or is not in good standing with the programs. A MCO will be able to establish quality measures for contracting with facilities (6.2.2.5).

Question: Am I required to provide a letter of support for MCOs?

Answer: No, this is not a requirement of the Department.

Question: Are providers required to use an intermediary to join an MCO provider network?

Answer: No, this is not a requirement of the Department.

Question: We are a substance abuse evaluation (and in the future treatment) program. We currently bill through Magellan. Do we fall under the physical and behavioral health care section where we will need to negotiate with an MCO after June 30, 2016?

Answer: Unless you are a Community Mental Health Center, your agency will need to negotiate with the MCO after June, 2016. Iowa Department of Public Health (IDPH) will procure the provider network for IDPH funded services.

Question: What coverage will MCOs be required to have for out-of-state providers? We currently use five out-of-state providers as the services they provide currently or at one time were not available in state. If we are unable to use some of these providers our child's quality of life will drastically decrease.

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Answer: There is no requirement that MCOs must contract with out-of-state providers. However, MCOs must have a provider network that meets access standards and all of the medical needs of its members.

Question: How does the cost report and rate setting methodology and processes for rebasing change with Nursing Facilities (NFs) & MCOs? Will DHS be seeking regulatory and legislative changes to change the rate setting methodology outlined in IAC Chapter 481-81 and 249A to allow the MCO to pay different rates?

Answer: The provider network and current rates will remain in place for nursing facilities until December 31, 2017. Provider network and reimbursement rates after this time period will be negotiated by the MCOs and providers as the MCOs establish their networks.

Question: Will the DHS require that the negotiated rates with MCOs for facilities, Home and Community-Based Services (HCBS) waivers and CHMC providers after December 2017 not be less than payment equal to the provider specific payment rates calculated by the Iowa Medicaid Enterprise within the current regulatory requirements for rate setting, while allowing the MCO to negotiate mutually acceptable higher rates for patients requiring more complex medical care? Or do you expect to change regulations to allow the MCOs to pay providers lower rates than current regulations and statutory language?

Answer: At a minimum, we expect Medicaid rates will continue at the rate in effect as of December 31, 2015.

Question: How will you make certain payment rates are consistent and sufficient across MCOs?

Answer: The MCOs will be required to have adequate provider networks and current payment rates will remain in place for physical and behavioral health care services until June 30, 2016, and for facility, HCBS and habilitation services until December 31, 2017. Reimbursement rates after these time periods will be negotiated by the MCOs with providers. In a comprehensive risk-based managed care approach, MCOs are given flexibility to negotiate provider networks and rates. The state will be responsible for oversight of the MCOs.

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Section 8: Processing

Question: Will payments and client participation information still be available via the Iowa Medicaid Portal Access (IMPA) System?

Answer: Business processes and tools made available through the Department that have been built for approved purposes that will still be necessary after Modernization would continue to be supported.

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Question: How will the MCOs handle pay and chase claims? Title V Maternal and Child Health agencies do not bill private insurance. When clients are seen that have Medicaid as secondary coverage will the MCO pay and chase the claim as IME currently does?

Answer: The MCOs will handle pay and chase activities as described in the RFP in section 13.6.2.3.

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Section 9: Prior Authorization

Question: The current Medicaid HMO requires prior authorization for therapy (speech, physical and occupational therapies). MCOs typically approve a specific number of visits within a designated time frame. At this time, requests for prior approval for continued therapy need to be submitted up to two weeks prior to the current authorization expiring as there is at least a two week delay in receiving approval for additional visits. Will there be a mechanism put in place to make sure the MCOs have sufficient staff in place to process requests for additional visits without an interruption in services?

Answer: Yes, MCOs must have sufficient staff in place to process requests without an interruption in service.

Question: Could you please share how diabetic supplies will be managed under the Medicaid Modernization? Who will decide what products will be available to Medicaid patients? What will be the process for patients to secure diabetic supplies?

Answer: Coverage for medically necessary supplies and services remain consistent with what is already in place. Details about specific authorization guidelines, products and other requirements may change slightly based on the MCOs approach to coordinating patient care. Providers and members will need to follow processes set by the MCOs.

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Section 10: Pharmacy Services

Questions and answers to come

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Section 11: Reporting

***NEW Question: Mental Health and Disability Services (MHDS) systems redesign requires outcomes and performance measurement and reporting. How will MCOs**

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contribute to and participate in this statewide outcomes and performance measurement effort? Is this an area where DHS will exercise the option to require cross-contractor consistency as stated in Section 2.11 of the RFP?

Answer: All stakeholders must work together to achieve positive outcomes for individuals with disabilities. The MHDS regions are one of the stakeholders that the MCOs are required to work with.

Question: Why will MCOs have the discretion to ask for additional reporting outside of what the Iowa Medicaid Enterprise (IME) currently requires? This will create inequalities amongst the MCOs. If multiple MCOs serve the same provider, it can lead to different reporting requirements and additional burden on the provider.

Answer: There are a number of reporting requirements identified in the RFP for all MCOs. In order for the MCO to meet the requirements, they may require specific information from each contracted provider. The MCOs will have discretion to require their own reporting so they may effectively monitor their business and meet the state reporting requirements.

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Section 12: Requirements

***NEW Question: If two to four MCOs are operating statewide with providers likely contracted to more than one, it seems that one statewide training and certifications “system” would be most effective and efficient. How will the MCO contracts continue these efforts and deal with issues of provider and staff qualifications?**

Answer: The state will work with the MCOs to ensure that they are adhering to the state standards for provider enrollment and training while leveraging existing tools.

***NEW Question: Who specifically will be overseeing and enforcing performance and delivery of services to the consumer?**

Answer: The MCOs will be overseeing and enforcing the expectations for their provider network. DHS will be monitoring this MCO work and providing oversight to ensure that all grievances are handled timely and to the member's satisfaction when possible. The MCOs will also undergo an external quality review each year to ensure contract compliance and performance.

Question: When implementing the use of MCOs for managing Medicaid, will there be a cap on the amount of profit an MCO can obtain through their management? Is there a requirement to reinvest the dollars earned over the profit limit?

Answer: A Medical Loss Ratio (MLR) and administrative percentage will be applied to all payments made to MCOs. MLRs include all expenditures associated with members' care while the administrative percentage includes MCO care coordination, case management, and other costs associated with doing business. If medical costs for

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members do not meet the minimum MLR assigned, the state may recoup the difference. Profit can only be achieved if there are funds remaining in the administrative percentage.

Question: Will there be requirements to assure that the MCOs have adequate contracts in rural areas? How will the state assure that small rural nursing homes, medical care providers, home health providers, pharmacies, or current HCBS waiver program providers will be able to continue to provide services to members as opposed to the MCOs contracting with large corporations only?

Answer: Please see the specific access standards for different provider categories in Exhibit B of the RFP Scope of Work. MCOs will be expected to contract with quality providers to ensure access standards, regardless of the size of the provider agency.

Question: Some organizations have waitlists that are over six months. Will MCOs be required to cover persons through an existing service provider until a spot opens at an MCO covered provider?

Answer: During the transition period as described in the RFP, the contractor (MCO) will be required to utilize the current providers that have been utilized by the member. Section 6.2.5 of the RFP states: "If the Contractor is unable to provide medically necessary covered services to a particular member using contract providers, the Contractor shall adequately and timely cover these services for that member using non-contract providers, for as long as the Contractor's provider network is unable to provide them. The Contractor shall negotiate and execute written single-case agreements or arrangements with non-network providers, when necessary, to ensure access to covered services."

Question: What will be the contract award terms for the MCOs? How will their effectiveness be monitored? Will an MCO have to reapply after a term to continue to provide services?

Answer: The contract award terms are included in the RFP document. The contract terms will be monitored to ensure that the MCOs are operating at least as noted in the RFP. Contract non-compliance will be approached as outlined in Exhibit E of the RFP Scope of Work. The base term of the MCO contract is three years. After the base term, the state has the option to renew the contract two times for an additional two years per renewal.

Question: Page 91 speaks of "risk sharing agreements" the contractor has arranged with a provider. Based on best practices, what kind of arrangements might be made?

Answer: For example, a MCO may choose to pay providers a dollar amount per member per month to provide all of the care for that member. Any type of risk sharing arrangement must be approved by the Department and shall follow federal regulations.

Question: Page 122 - Will all contractors use the same health risk screening tool? Who will administer?

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Answer: A uniform tool is preferred across contractors for comparability of data. (See RFP Section 9.1.1.1)

Question: What is to prevent the selected MCOs from working together to engage in “price fixing”?

Answer: Price fixing is an illegal activity and will be referred to appropriate law enforcement agencies.

Question: We are a Chapter 24 outpatient mental health facility with both full and temporary licensed mental health counselors, marriage family therapists and social workers on staff. Currently temporary licensed mental health providers for all three disciplines may be credentialed with Magellan. Would the contract holders (MCOs) be expected to credential the same professionals, regardless of whether they have a full or a temporary license, to ensure that clients can have continuity of care and provider agencies can continue to support the training and preparation of mental health professionals for full licensure as they have been? Will ample time be provided to allow all the providers the necessary time to complete any credentialing requirements for all the contract holders? And will agency status be afforded to Chapter 24 mental health agencies so that those agencies can credential their own mental health professionals as they do now?

Answer: Providers eligible enroll with Medicaid today will be eligible to contract with MCOs in the future unless rules and regulations change.

Question: In our county, we achieve cost savings by having case management services account for many service/program related functions (normal role, but adjustment of language/expectations) that essentially eliminate or reduce a need for duplicate provider staff to write an acceptable, individual, consumer plan that is in conformance with not only State rules, but accreditation organizations such as CARF. With care coordination being determined by the MCOs, will there be steps taken to avoid provider staff of having to hire additional employees to fully comply with consumer case record/plan standards?

Answer: As noted, the intent of the RFP is to develop efficiencies within the service system including the coordination of plans and documentation requirements. Each MCO will have operational procedures on how this task or coordination will work.

Question: Many managed care organizations have their own definitions for what constitutes “medical necessity”. Will the IME require medical necessity statements come in line with current Medicaid policies?

Answer: Yes, medical necessity and utilization management guidelines shall be reviewed and approved by the Department.

Question: Have you considered how we are going to make Medicaid members accountable for their own care and compliant with the managed care organization coordination efforts?

Answer: MCOs bring specific expertise in this arena. They are expected to provide active education and outreach to their enrolled members to encourage healthy behaviors and promote health care accountability. In addition, MCOs may develop

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programs that incentivize member accountability and healthy behaviors. The Department expects overall member engagement and compliance to increase significantly under Modernization.

Question: With the possibility of up to four MCOs being allowed to contract with Medicaid, will a mechanism be put in place for uniformity in reimbursement, prior approval for services, definition for medical necessity for services, etc.? Or is the provider expected to learn the “ins and outs” for each of the MCOs?

Answer: Providers will be expected to work with MCOs to understand how each company may differ in process and contracting. All MCO specific information shall be accessible to all providers. There will be some uniform requirements that all MCOs will be required to meet. Each MCO will have their own policies and procedures that contracted providers will be expected to follow.

Question: Many providers have invested in software that works with the current billing remittance platform utilized by Iowa Medicaid (PC-Ace). With the transition to bills submitted to multiple MCOs, will there be assurances that MCOs will utilize the same platforms across MCOs? Will steps be taken to ensure compatibility with current provider systems that work with Iowa Medicaid?

Answer: MCOs will identify their own Electronic Data Interchange (EDI) mechanism to move information from provider to payer and back. That may mean different tools are offered or utilized by different MCOs. PC-Ace is a specific claim submission tool that is used by Medicaid providers. All health care transactions flowing through any EDI vendor are required to follow certain, defined standards (per the Health Insurance Portability and Accountability Act of 1996 (HIPAA)). Any software a provider has purchased to communicate to a health care payer should be easily connectable to whatever EDI an MCO has in place.

Question: Medicaid currently allows provision of services in a variety of locations outside of the traditional clinic setting (i.e., private homes, daycare facilities, etc.). Many MCOs only allow services to be provided in a clinic setting. Will MCOs be mandated to allow services to continue to be allowed in a variety of settings?

Answer: MCOs will continue to provide the same services that Medicaid allows today in a variety of locations. The MCOs will establish utilization guidelines to assure appropriate services are provided at the right time, in the right way and in the right setting.

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Section 13: Appeals

Questions and answers to come

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Member Questions

Section 14: Differences in Services

Question: A few programs will be excluded from coverage under the Managed Care Organizations like PACE and Alaskan Native/American Indians (member option), programs where Medicaid already pays premiums (Health Insurance Premium Payment Program (HIPPP) or eligible for Medicare Savings Program) and undocumented person's eligible for short-term emergency services only. Does this mean that Medicaid services will stay the same as they are today for these programs and be managed by DHS?

Answer: Yes, the services will stay the same. Members in these programs will continue to receive services from enrolled Medicaid providers and paid by DHS through the fee-for-service system.

Question: For an individual with a Traumatic Brain Injury who is eligible for both Medicaid and Medicare and receives services under the Brain Injury (BI) waiver, what will remain the same or change under managed care for the Medicaid part of payment for health care and medicine? What about waiver services and case manager? What about Medicare?

Answer: All the Medicaid state plan and Home and Community Based Services (HCBS) waiver benefits available today will continue to be available through the MCO. This includes prescription medicine and the BI waiver services. Dental services will stay the same, and will not be provided by the MCO. After the change occurs, the MCOs will be responsible to provide community-based case management services. It will be for the MCO to decide if they will work with the current case managers or provide the service themselves. If Medicaid pays the Medicare premiums for a member eligible for both Medicaid and Medicare programs, that will also continue. The changes for managed care affect only Medicaid, the changes do not affect Medicare.

Question: Please explain why reading to an individual who is completely blind, receiving CDAC services in the Brain Injury waiver, is no longer going to be covered under CDAC.

Answer: The service under Consumer Directed Attendant Care (CDAC) has not changed within this RFP. CDAC is defined in the Iowa Administrative Code as a service that includes:

- bathing
- dressing
- hygiene
- grooming
- assistance with transfers
- ambulation or general mobility
- toileting
- meal preparation including cooking and assistance with eating
- housekeeping
- laundry
- shopping essential to the members health care at home
- assisting with medication
- minor wound care

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- assistance with transportation to work
- financial management
- communication essential to the health and welfare of the member through

interpretation and reading services

- transportation important to the health and welfare of the member

Reading that is important to the health and welfare of the member will continue to be covered.

Question: What is the future of out-of-state placements for individual receiving services in an out-of-state psychiatric medical institution for children (PMIC) with the new plan?

Answer: During the transition period, the MCO will be working with members and their families to learn if the current service package is meeting the needs of the Medicaid member or if there are other services within the state that could also meet their needs. So, services in out of state PMICs could continue if appropriate or the MCO would match other appropriate services within the state with the member.

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Section 15: Enrollment

Question: Will there be requirements or financial transparency for MCOs to help consumers be better informed consumers when choosing a plan?

Answer: Like today's managed care programs, there will be a person/agency that is completely separate from the MCOs that will share member materials and help members with choices in a fair way.

Question: How will members be educated on how their services will change/look in the new system so that they can have a positive experience during the transitional time? If individuals have a guardian, will the communication go to the guardian or the member?

Answer: The Department is developing a member outreach plan to make sure members know of any changes. Those who are a part of the new plan will have help in picking a managed care organization effective January 1, 2016. Members will continue to receive their information as they do today; so, if a member's guardian currently receives the information, that process will continue until the member chooses to change this.

Question: Why are members allowed to choose their own MCOs instead of setting MCOs based on where the member lives? If people move from one MCO to another, will MCOs see a member's health information to properly manage a member's care without having duplication of services? Keeping MCOs based on where the member lives allows providers to work with only one MCO for continuity of service between MCOs and providers.

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Answer: MCOs will be required to manage member's care and help with changes when a member moves from one MCO to another. MCOs must have statewide coverage to allow for members to move through the state without having to change coverage.

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Section 16: Services

***NEW Question: How are Medicaid waiver waiting lists expected to be impacted or addressed by Medicaid Modernization and the MCOs?**

Answer: The waiver waiting lists will continue to be managed by DHS. Additional slots cannot be created without legislative appropriations.

Question: In what cases will there be a waiting list for HCBS?

Answer: Currently there are waiting lists for five of the seven HCBS waivers. Waiting lists will continue as is unless enough funds are added to the Medicaid budget to increase the number of members served through each of the HCBS waivers.

Question: How will the Support Intensity Scale be tiered for payment for HCBS/ID services? What are the ranges of index scores for each tier?

Answer: At this time, the Department has not developed the tiers for HCBS/ID program and therefore cannot provide the ranges or how a tiered program may operate.

Question: If an Iowa Family Planning Network (IFPN) member has insurance, but has to claim confidentiality, can she then qualify?

Answer: Yes. Claiming confidentiality (or requesting that your information remains private) is not an eligibility factor for IFPN. Patients can have insurance that covers family planning services as well as claim confidentiality and still be eligible for IFPN.

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Section 17: Providers

Question: In what circumstances can a contractor refuse to fund services in the facility or from the provider of one's choice? Is there real choice when 6.2.1 includes the words "to the extent possible?"

Answer: Members will have a choice in provider from those included in the MCO network. The MCO must describe how it will make sure members have the right to select providers without regard to how they are paid. If a member enrolls with an MCO and already has a relationship with a provider not included in the MCO network, the

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MCO is required to make every effort to make sure the member can stay with the same provider, if the member wants to. Members may also switch to a different MCO if the provider is in another MCO network, and the member chooses to maintain the established provider relationship.

Question: As I understand it, there will be up to four managed care plans to choose from each of whom will have a list of providers. My daughter currently has three major doctors: her internist, her cardiologist and her psychiatrist. She also gets Home and Community-Based Services (HCBS) from three providers largely because she has relationships with the direct service providers which aren't easy to establish. What if some of the doctors and service providers are in one network and some in another? My daughter has a very, very difficult time with any change and I am concerned about rocking the "apple cart" which can send her into years of difficulty.

Answer: The member should choose the plan that best fits their needs. The MCO is expected to work with the member to ensure the best care coordination possible.

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Section 18: Appeals

Questions and answers to come

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Section 19: Questions and Comments

***NEW Question: How long has the state been considering transitioning Medicaid services to managed care?**

Answer: Many Medicaid services have been included in a managed care structure for decades. Behavioral health services have been incorporated in the managed care program called the Iowa Plan and the Department has also had multiple Health Maintenance Organizations (HMOs) for quite some time. The concept of creating a comprehensive managed care program for the majority of Medicaid services has been in development for several months.

Question: Are all the questions and comments submitted included in an amendment to the RFP?

Answer: The Department is reviewing all questions received from interested parties and is creating a list of frequently asked questions and answers published on the dedicated web page <https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>. All comments about changes to the design of the RFP are reviewed for consideration. Some suggestions may be added into an amendment to the RFP, while some

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comments may be addressed at a later stage in the operational design of the program or in the final contract with the MCOs.

Question: Where do we find the question and answer sections to be posted on website?

Answer: The link to the updated “Frequently Asked Questions” document can be found at: https://dhs.iowa.gov/sites/default/files/IME_MedicaidModernization_FAQ.pdf. Additional information about Medicaid Modernization, including the question and answer document can be found at the dedicated web page: <https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>.

Question: The presentation materials indicated that there was a stakeholder comment deadline of March 20 2015, but it is unclear what that is referring to.

Answer: The Department requested input from stakeholders on the Medicaid Modernization initiative. An email mailbox has been set up to receive questions and comments from interested parties at: MedicaidModernization@dhs.state.ia.us. The Department is reviewing all questions and is making a list of frequently asked questions and answers made available at: <https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>. All comments on changes to the design of the RFP are considered to be incorporated into an amendment to the RFP. In the RFP timeline, an amendment was expected by March 26, 2015. Comments needed to be received before this date to be worked into the amendment. An amendment was posted on March 26, 2015. We encourage interested parties to continue sending questions and comments, to be included into the frequently asked questions.

Question: How can I obtain a list of bidders?

Answer: Interested bidders for the Iowa High Quality Health Care Initiative Request for Proposal (RFP) were asked to submit a letter of interest to the Iowa Department of Human Services. Those letters were due on March 11, 2015. A letter of interest does not guarantee a bidder will submit a proposal, but does indicate interest to the Department. In total, seventeen letters of intent were received as of March 11, 2015, from potential bidders. Interested parties may see the list of interested bidders on the [Bid Opportunities web page](#).

Question: With the pending changes for persons covered, why were Medicaid participants not directly notified of the pending changes?

Answer: The Department has issued several press releases on the Medicaid Modernization initiative. Those included notifications of the issuance of the Request for Proposal for the Iowa High Quality Health Initiative, notices of a series of public meetings to be held on the initiative, announcements where information could be found on a dedicated web page and how to submit questions and comments to a dedicated email box. Communications were also made to a number of advocacy groups and organizations representing Medicaid members to ensure members were

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aware of pending changes. Individual communications to Medicaid members are planned prior to implementation.

Question: Is it possible for us to obtain a list of those attending meetings, specifically, from the March 16 meeting in Council Bluffs?

Answer: To request a list of individuals who attended the public stakeholder meetings, please contact: IMECommunications@dhs.state.ia.us.

Question: Where can I find information that describes what the MCOs will be reporting to the Department?

Answer: A draft of the reporting manual will be located in the bid library at: http://dhs.iowa.gov/MED-16-009_Bidders-Library

Question: Page 126 Section 10.1.2.12 references an Iowa Participant Experience Survey. I would like to find out more information about that survey instrument and process.

Answer: Please see the bid library for more information.

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Medicaid Modernization Request for Proposal Fact Sheet

The information provided in this document reflects the Medicaid Modernization as defined by the scope of work in the agency's request for Proposal (RFP), Iowa High Quality Healthcare Initiative, RFP# MED-16-009, issued February 16, 2015.

The Agency's written and oral responses to questions issued through this forum will not be considered part of the Iowa High Quality Healthcare Initiative RFP. If the Agency decides to change the RFP, the Agency will issue an amendment.